At the Crossroads of Empathy and Evidence in Modern Medicine

"Pain is a solitary truth that defies communication….To live in pain is to live in isolation"—these words underscore the painting *Resonance: Erasure* (Figure 1) by artist Susan Gofstein (Gofstein). It depicts a grief-stricken woman, her face disfigured by angry blotches of paint that blend with the background. For Gofstein, the reality imposed by her infirmity is unforgiving, stripping away identity and fomenting isolation. An outside observer may inquire how one can be so hopeless and desperate. After all, is not modern medicine at the precipice of eradicating pain and disease? At first glance, this assumption may appear to be true. At the onset of the nineteenth century, knowledge of biochemistry and the human anatomy increased rapidly, revolutionizing the field of medicine (Morris 194). The world's most terrible diseases, such as smallpox, fell victim to vaccination and other inoculatory procedures, and the grave uncertainty surrounding even the most common illnesses was reduced in light of germ theory. Physicians modified their practices accordingly, giving birth to contemporary medicine: "The science or practice of the diagnosis, treatment, and prevention of disease" ("Medicine"). Despite an ability to address disease effectively, modern medicine often struggles to treat the patient. In other words, the litany of biomedical examinations and pharmaceutics falls short of fostering patient-centered care (Ratzan 2). The obvious predicament faced by Gofstein and so many others, in this modern era of

Figure 1: *Resonance: Erasure* (Susan Gofstein)

medicine, can be resolved by acts of clinical empathy. Such empathy provides critical support to the biomedical methods of treatment and fosters a constructive environment in which physicians can operate.

Before speaking to these impacts of clinical empathy, it may help to discuss what actually constitutes this form of empathy. Clinical empathy, not to be confused with sympathy, is an act or behavior by doctors that leads patients to feel understood and accepted. The sense of understanding and acceptance arises from the physician's ability to take on a patient's point of view and relate this perspective back to the patient in order to improve the patient's emotional demeanor. (Kim, Klapowitz, and Johnston 237) While researchers and educators disagree on the exact details of this definition, all emphasize the contributions of empathy in modern medicine.

While doctors of the past readily embraced dialogue and relationship with their patients as a primary step in healing, modern caregivers increasingly rely on scientific, objective models during patient interactions, diagnoses, and treatments (Burke 133). This pathophysiological focus has reduced the danger of infectious disease and improved standard markers of public health, benefiting humanity as a whole (Engel 131). However, it remains an unbalanced approach. The great deal of emphasis placed on the technological aspects of medicine ousts the humanistic elements, stunting the overall effectiveness of care (Marcus 1211). It cannot be emphasized enough that this reductionism has in fact brought forth the most innovative and effective treatments; however, such treatments are not guaranteed to correlate with patient satisfaction or compliance if clinical empathy is lacking (Engel 129). As George L. Engel, a pioneer in the effort to supplement modern care with empathy, notes, "clinical study amounts to the study of one person by another, and dialogue and relationship are its indispensable tools" (Hojat 78). To understand this point, consider empathy's ability to reinforce evidence-based medicine in actual

workplaces.

Dr. Dana Mathew, of Raleigh, North Carolina, is an experienced emergency medicine physician with over twenty years of experience, regularly stresses that empathizing with "the person behind the patient" is fundamental in evidence-based medicine (Mathew). She recalls a moment as a medical student when she took the time to genuinely familiarize herself with one of her patients, despite his poor condition and her demanding schedule. He opened up to her over the course of the treatment period, speaking freely of his family, past career, and concerns. As her coworkers also entered into the dialogue, "how he was seen and treated changed immediately" (Mathew). Beyond feeling treated for his infirmity, the man simply felt appreciated. His compliance and satisfaction rose considerably as a result, paving the road for a shorter hospital stay and a longer period of good health afterwards. Amid the tests, examinations, and pharmaceutics that address the physical disease, empathy can extend an open hand for the patient to take.

Unfortunately, Dr. Mathew's experience with the elderly man is not guaranteed in medicine. In fact, while many pathological conditions can be effectively diagnosed and cured with strong degrees of clinical certainty, chronic illness lacks such certainty. Patients, like Susan Gofstein, who are afflicted by nonmalignant chronic pain are especially disadvantaged. Despite suffering tremendously from bodily pain, the most proven biomedical procedures rarely provide closure and comfort to these patients. This situation represents a paradox that weighs on the shoulders of patients and caregivers alike: the esteemed biomedical model cannot explain or eradicate overwhelming pain. These patients seek more than biomedical answers as they realize that their infirmity cannot be accounted for by biochemical evidence; they seek to be understood and accepted (Engel 130). As one may suspect, clinical empathy is the primary means of

fulfilling this desire. Without this understanding and acceptance, the condition of any patient suffering from a seemingly irreparable disease can only worsen.

Having considered these points, it should be clear that a return to the fundamentals of caregiving not only supplements evidence-based medicine but also stems the psychosocial strain of even the most debilitating disease. Patients such as Susan Gofstein fall outside of the biomedical model's scope. Therefore, it is purposeful, genuine interpersonal relationships that restore hope and positivity in such advanced care patients (Hojat xv). While the biomedical model treats disease on the basis of scientific evidence, clinical empathy treats the patient on the basis of humanity. Bringing these two approaches together has the net result of effective, patient-centered care. Beyond anecdotal evidence, medical research routinely produces empirical evidence suggesting that two principle outcomes of health care — patient satisfaction and compliance — are strongly correlated with empathic, communicative behaviors between the physician and patient (Kim, Klapowitz, and Johnston 238). Patients clearly benefit from clinical empathy. However, it must also be emphasized that physicians experience benefits as well.

Healthcare professionals bear witness to discomfort, suffering, and pain on a daily basis. The physical, mental, and social tolls are relentless, taking the form of fatigue, depression, anxiety, and irritability among other things (Gundersen 145). Over time, physicians come to associate these strains with patients, and the result is devastating to patient-centered care: the patients become viewed as the fundamental source of distress for the physician (Ratzan 3). This pattern repeats and intensifies during the careers of medical professionals unless it is broken. Clinical empathy is the ideal tool for breaking this vicious cycle. Mohammadreza Hojat, a distinguished researcher in the field notes, "an empathic clinician-patient relationship can improve the physical, mental, and social well-being of the clinician…" (Hojat xv). These words

are noteworthy, for they suggest that empathy is in fact a two-way street.

To illustrate this point, it helps to first consider what fuels the working spirit. In other words, how are members of any profession able to persevere through years of relentless, hard work? The answer is two-fold: social connection and perceived control (Gundersen 146). From the standpoint of social connection, one sees an array of benefits for the individual. However, the most important of these for physicians is the sense of satisfaction. When physicians engage in empathic behavior, through communication with the patient or family, a degree of social connection is established. Through this connection, the fundamental human need for affiliation, understanding, support, and satisfaction is fulfilled. (Hojat 71) Doctors are not immune to the stressors that characterize their work environments. Practicing clinical empathy and developing social connections serve to buffer physicians from these stressors in much the same way that patients are comforted by the empathy of others.

In addition to preserving work satisfaction through social connection, clinical empathy also fosters a sense of control within the physician. As the hours of a single workday mount, healthcare professionals often feel subjected to the tide of incoming patients and unanticipated challenges. Physicians who practice clinical empathy are shown to exhibit higher levels of professional development, understanding, and perception of control (Adams 56). This perceived control correlates directly with increased levels of physical, mental, and emotional resilience (Gundersen 146). The general efficacy of physicians hinges on resilience in these areas. It is logical that the more resilient a physician is, the more likely he or she is to provide balanced, patient-centered care.

It should be clear as to how impactful clinical empathy is in modern medicine. Its natural emphasis on humanistic elements of care offers critical support to the technologically geared

biomedical model. The impact of this support is evident in research and professional anecdotes alike. Patients who perceive strong levels of empathy within their physicians are likely to be more satisfied and compliant with their care (Kim, Klapowitz, and Johnston 237). On the other hand, physicians who exercise clinical empathy experience a variety of benefits as well, including gratifying social connection and a positive sense of control. It must be stressed that the points made here are not intended to belittle the biomedical model of caregiving. Nor are they intended to overemphasize the true utility of clinical empathy in modern care. They are intended to contribute to an ongoing discussion of how the medical field can be improved for the sake of patients and healthcare professionals alike. A primary step in developing such improvements may come from continued, genuine practice of clinical empathy by physicians.

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